

Registration District No. 791

Primary Registration District No.

Registrar's No. 5010

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME John Bela Chilcote

3. (b) If veteran, name war _____

3. (c) Social Security No. 702-14-3780

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Evelyn 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 18, 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 3 29 hr. min.

9. Birthplace Onaga Kansas /
(City, town, or county) (State or foreign country)

10. Usual occupation Foreman

11. Industry or business Missouri Pacific R. R. Co.

12. Name Simpson B. Chilcote

13. Birthplace Iowa /
(City, town, or county) (State or foreign country)

14. Maiden name Frances Inglesbe

15. Birthplace unknown /
(City, town, or county) (State or foreign country)

16. (a) Informant Clyde C. Chicote

(b) Address Fostoria Kansas

17. (a) Removal (b) Date thereof 6/18/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Rapids, Kansas

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) JUN 18 1941 (b) J. H. Braddock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Marshall
(c) City or town Blue Rapids
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 17
year 1941 hour 2 minute 40 A. M.

21. I hereby certify that I attended the deceased from 6/15/41, 19____, to 6/17/41, 19____;
that I last saw him alive on 6/17/41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Congestive Heart Failure 1 week
Due to Chr. Myocarditis
Chronic Bronchial Asthma

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Charles C. Duach (M. D. or other) MD
Address 1755 So. Main Date signed 6/17/41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.